

# Comprehensive Medical Assessment (Item 712) and Nursing Admission Form

Shaded sections to be completed by admitting Registered Nurse/Manager

Aged Care Home \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Name of resident \_\_\_\_\_ Date of Birth \_\_\_\_\_

Resident Status  New  Existing

Medicare number \_\_\_\_\_ Private Health Fund \_\_\_\_\_

Pension number \_\_\_\_\_ DVA number \_\_\_\_\_

Name of Enduring Power of Guardian (if applicable) \_\_\_\_\_

Name of Enduring Power of Attorney (if applicable) \_\_\_\_\_

Is there an Advanced Care Plan?  Yes  No

*Spiritual / Religious Practices*  Yes  No

*Chaplain Visits*  Yes  No

*Holy Communion*  Yes  No

*Last Rites*  Yes  No

*Funeral Arrangements*  Yes  No

EPC Care plan  Yes  No

EPC Case Conference  Yes  No

Consent for RMMR review obtained  Yes  No

Resident Medication Management review  Yes  No

## CMA Service Details

Provided by Dr: \_\_\_\_\_

Telephone \_\_\_\_\_ Mobile \_\_\_\_\_ Fax \_\_\_\_\_

Is this the resident's usual doctor?  Yes  No

If No, has a copy been provided to the resident's usual doctor?  Yes  No

Has the resident had a previous CMA?  Yes  No Date: / /

Consent for a CMA obtained?  Yes  No Date: / /

Consent given by:  Resident  Representative (name): \_\_\_\_\_



# Comprehensive Medical Examination

## Cardiovascular System

Blood Pressure	Systolic	Diastolic	Heart Rate
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**Identified Problems:** ( To be completed by Nurse, Manager or Medical Practitioner)

**Required Action:** ( To be completed by Nurse, Manager or Medical Practitioner)

## Respiratory System

<b>Dyspnoea</b>	At Rest	<input type="checkbox"/> Yes	<input type="checkbox"/> No	On Exertion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Cough/Sputum</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No			
<b>Smoking</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No	No. per day		

**Identified Problems:** ( To be completed by Nurse, Manager or Medical Practitioner)

**Required Action:** ( To be completed by Nurse, Manager or Medical Practitioner)

## Pain

**Acute**

Yes

No

**Chronic**

Yes

No

If Yes, what causes the pain, specify location of pain and commence pain assessment chart:

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**Required Action:** ( To be completed by Nurse, Manager or Medical Practitioner)

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## Physical Function

**Ambulant**

Yes

No

**Assistance Required**

Yes

No

**Chair / Bed Bound**

Yes

No

**History of falls**

Yes

No

**Specific Assessment Required**

Yes

No

(e.g. Falls Assessment)

**Shower independently**

Yes

No

**Dressing**

Independent

Supervised

Assisted

**Grooming**

Independent

Supervised

Assisted

**Identified Problems:** ( To be completed by Nurse, Manager or Medical Practitioner)

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**Required Action:** ( To be completed by Nurse, Manager or Medical Practitioner)

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## Sensory

<b>Normal Hearing</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Wax Occlusion		
<b>Hearing Deficit (Left)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Hearing Deficit (Right)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Hearing Aid (Left)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Hearing Aid (Right)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Audiologist Visit</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Date</b>	.....	
<b>Normal Vision</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

**Identified Problems:** ( To be completed by Nurse, Manager or Medical Practitioner)

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**Required Action:** ( To be completed by Nurse, Manager or Medical Practitioner)

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## Nutritional Status

<b>Weight (kg)</b>	.....		<b>Height (m)</b>	.....		<b>BMI</b>	.....	
<b>Alcohol Consumption</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>No. Standard Drinks</b>	.....				
<b>Special Dietary Needs</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Please Specify</b>	.....				
<b>Feeds Self</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Type of Assistance</b>	.....				
<b>Chewing/Swallowing Concerns</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Speech Therapist Assess.</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
<b>Wears Dentures</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Upper	<input type="checkbox"/> Lower	<input type="checkbox"/> Full	<input type="checkbox"/> Partial		

**Identified Problems:** ( To be completed by Nurse, Manager or Medical Practitioner)

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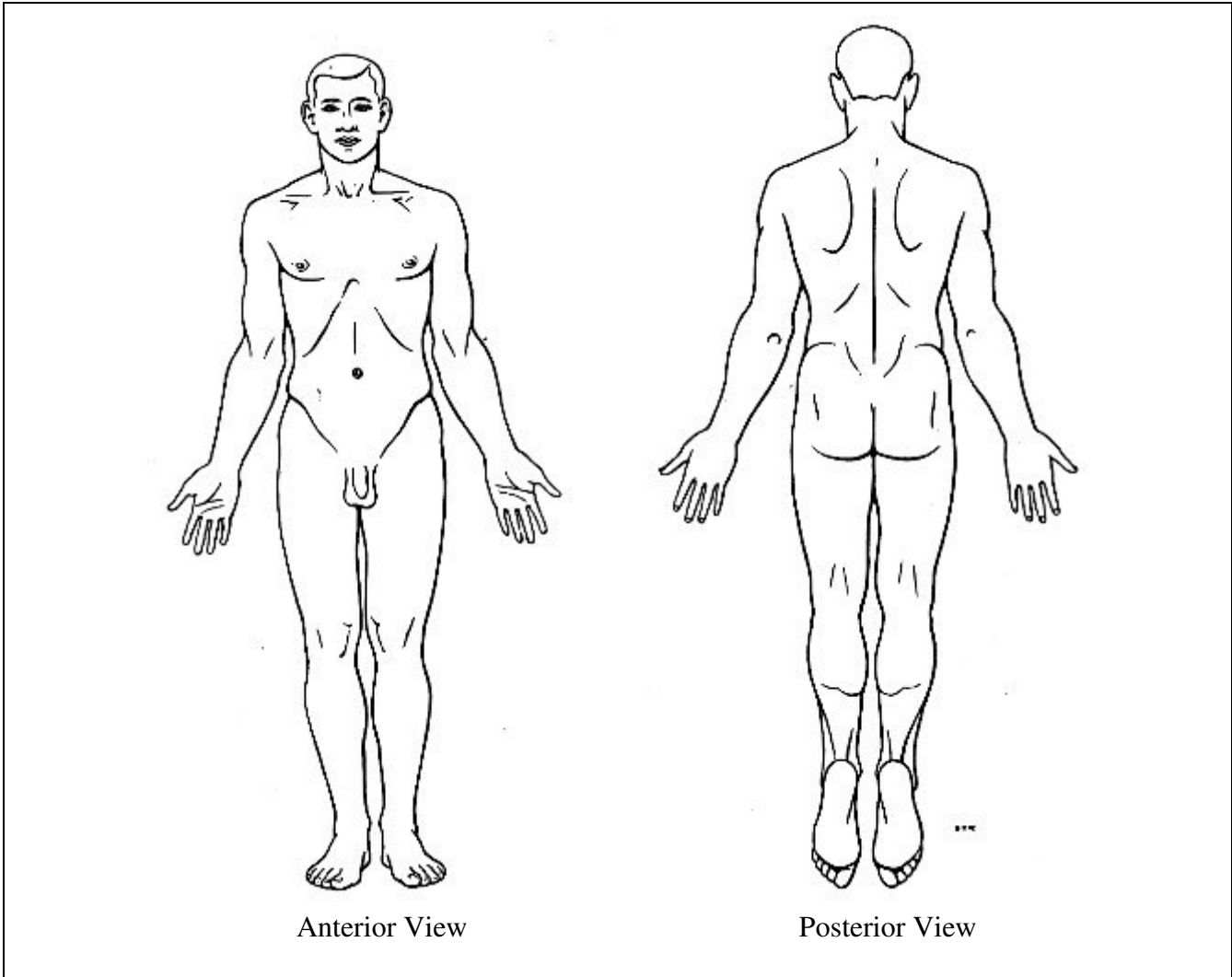
**Required Action:** ( To be completed by Nurse, Manager or Medical Practitioner)

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**Skin Integrity:** (detail area which is bruised, ulcerated, has a rash, is reddened or has a wound)



**Identified Problems:** ( To be completed by Nurse, Manager or Medical Practitioner)

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**Required Action:** ( To be completed by Nurse, Manager or Medical Practitioner)

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## Elimination

### Urinary

Self Toilets  Yes  No **Needs Prompts / Assistance**

Frequency/Urgency  Yes  No

Incontinent  Yes  No

### Bowels

Self Toilets  Yes  No **Needs Prompts / Assistance**

Constipation  Yes  No

Stoma  Yes  No

Incontinent  Yes  No

**Identified Problems:** ( To be completed by Nurse, Manager or Medical Practitioner)

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**Required Action:** ( To be completed by Nurse, Manager & or Medical Practitioner)

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## Psychological Function

**Dementia**  Yes  No

**Agitation**  Yes  No

**Aggression**  Yes  No

**Wandering**  Yes  No

**Psychosis**  Yes  No

**Depression**  Yes  No

**Insomnia**  Yes  No

**Required Action:** ( To be completed by Nurse, Manager or Medical Practitioner)

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